

FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34049

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

7858

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN BRENTWOOD	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mrs. Paci'fic Hospital		d. STREET ADDRESS 2824-MANDERLY	
3. NAME OF DECEASED (Type or print) Charles Washington Robertson		4. DATE OF DEATH Month 9 Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		11. BIRTHPLACE (City and state or country) ROBERTSVILLE-MO	
13. FATHER'S NAME THOMAS-H.B. ROBERSON		14. MOTHER'S MAIDEN NAME UNKNOWN O'BRIAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MARGARET-RUCK-ROBERSON		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 162x			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 8-1-57 to 8-20-57 and last saw him alive on 8-20-57 Death occurred at 11:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Clarence F. Greenman, M.D.		22b. ADDRESS Dr. Paci. Eng. Hosp. Assn.	
22c. DATE SIGNED 8-21-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-24-57	
23c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS CO., MO.	
24. FUNERAL DIRECTOR JAY B. SMITH - MAPLEWOOD-17-MO.		25. DATE RECD. BY LOCAL REG. AUG 22 57	
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me; or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 40

P. O. Address Maple

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.